Family Place Registration Form

Please check the following:

Family Place North	☐
Family Place South	☐

Date _____

Parent Name: _____ Date of Birth _____

Street Address _____ City _____

Postal Code_____ Email Address _____

Telephone: Home:_____ Mobile:_____

Emergency Contact Name: _____ Telephone: _____

Please Provide us with the following information:

Family Members: Spouse: _____ Date of Birth: _____

Child: _____ DOB: _____ Child: _____ DOB: _____

Child: _____ DOB: _____ Child: _____ DOB: _____

How did you hear about Family Place? _____

Relevant Medical Information (i.e. food allergies):

_____

Other relevant information or things you'd like to share regarding your child:

_____

Please tell us your ethnicity: _____

Do you identify as aboriginal? (please circle YES or NO): YES NO

Do you speak a different language other than English at home? If yes, please tell us what

language_____

Your information is considered confidential and will not be shared with any other agency/company.